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ABSTRACT

This collection of papers presented at a 1996 conference on children's mental health focuses on utilization research. Papers have the following titles and authors: (1) "Information Equity: A Critical Component of Strong Service Systems" (Catherine Batsche and Allison Metcalf); (2) "Utilization of Children's Mental Health Services: Differentiating Families Who Use Community-Based Services from Those Who Do Not" (Frances Johnson Niarhos and others); (3) "Children's Mental Health Needs and Services in an Urban Area: Mapping and Analysis" (Theodore Fallon); (4) "Addressing the Barriers to Mental Health Services for Inner-City Children and Their Caregivers" (Mary McKernan McKay and others); (5) "Referral Bias?: A Clinical Comparison of African-American and Caucasian Children Referred to a Child Psychiatric Outpatient Clinic" (Paula Armbruster and Mary Schwab-Stone). (Individual papers contain references.) (DB)

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8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Information Equity: A Critical Component of Strong Service Systems

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Information and Referral

Information and Referral (I & R) is a system designed to link a person in need of information about human services with needed resources. "I & R represents a continuum of functional elements ranging from information assistance and advice-giving to referral and follow-up" (Levinson, 1987, p. 914). I & R services generally provide information to individuals who telephone an agency, describe a problem, and request assistance. Trained staff assess the nature of the problem(s), provide information, and advice, appropriate referrals to existing resources, and follow-up to determine if services were obtained. "Varying levels of counseling and advocacy are offered in accordance with the user's needs and the mission of the I & R organization" (Levinson, 1987, p. 914). There are several different types of I & R services but most can be classified as one of the following:

General Assistance: agencies that serve all segments of the population and deal with a wide range of social problems.

Specialized: agencies designed to meet the needs of a specific target population (e.g., individuals with disabilities), to deal with a significant social problem (e.g., HIV/AIDS), or to provide a specific service (e.g., crisis intervention).

Full Service: agencies that serve all segments of the community and address a wide range of social problems; in addition, these agencies conduct and participate in a variety of community planning and needs assessment activities to improve the continuity of care in the human service system.

The philosophy of I & R is that being "information poor" is a handicap in obtaining services; being "information rich" enables one to reap the benefits of a service system (Levinson, 1987, p. 919). One goal of I & R agencies is to provide information equity so that individuals in need of help can obtain services in a timely manner.

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Importance of I & R Services

Early intervention is considered to be an important factor in the successful treatment of at-risk children and their families. Unfortunately, it is often difficult for people to identify and locate services in the early stages of a crisis. For example, 57% of respondents in a community needs assessment study reported that they did not get help for a personal or family problem because they "thought no help was available" (ICOPE, 1992). Whereas only 10% of the general citizenry in another study reported that they did not know where to find the help they needed (Balducci, 1994), this rate was 16% for low-income respondents, 23% for individuals who had experienced a serious problem within the last year, and 45%

for Spanish-monolingual respondents (Montenegro & Batsche, 1995). Lack of familiarity with service systems and service providers is a major barrier that reduces opportunities for early intervention.

In a recent article on early intervention with children with serious behavior problems, Dunlap and Fox (1995) describe "family support" as one of the major elements of comprehensive early intervention services. They refer to family support as "any and all actions that serve to strengthen the family system, especially as these actions pertain to the family's assimilation and understanding of their child's disability" (Dunlap & Fox, 1995, p. 18). Among the supports they describe are the need for information, education/training, and social and emotional support. Although the provision of on-going intervention is beyond the scope of I & R services, these organizations do provide information to help with the initial identification of service providers, support groups, and community activities. I & R counselors are also trained to teach families how to operate within a community-based social service system, i.e., self-advocacy training. Finally, I & R counselors serve as a source for help for individuals in need of emotional support for long-term problems and stresses.

In summary, I & R services are often the entry point into the system of care for children and families. These agencies can provide individualized ongoing support and services ranging from self-advocacy training to 24-hour social and emotional support. Little has been published describing the role of I & R agencies as part of early intervention strategies, a family support service, or a critical component of the continuum of care. The objectives of this project were therefore to:

1. identify sources of information used by individuals when they are in need of help;

2. identify barriers to obtaining information about community services that may prevent individuals from seeking early intervention assistance; and to

3. conduct an analysis of "counseling" calls received by an I & R agency to determine the nature of the crisis, the extent of intervention provided by phone counselors, and the extent to which counseling calls were referred to other service providers.

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Procedures

The methods used to address objectives one and two were focus groups, key informant interviews, and a survey of citizens. Focus groups and interviews were conducted with consumers of mental health and other social services and representatives from community social service agencies and organizations, state/county social service agencies, information-service agencies, and community churches and synagogues in Pinellas County, Florida. In selecting consumers to participate in the focus groups, target populations were identified who were representative of the demographic and cultural composition of the community including: Southeast Asian consumers, African-American consumers, and the elderly population. The social service providers included representatives from community schools, hospitals, public health centers, child care centers, domestic violence shelters, family service centers, mental health centers, and substance abuse treatment centers. The state/county agencies included representatives from Health and Rehabilitative Services, Juvenile Justice, Public Health, and Social Services. The participants in the focus groups with social services providers and state/county agencies were selected in consultation with members of the Pinellas County Interagency Council on Planning and Evaluation. Agencies were invited to participate who had extensive experience in dealing with individuals seeking assistance from public sector programs and services.

Finally, a survey of the general citizenry was conducted to identify the information-seeking behaviors and preferences of citizens of Pinellas County. One hundred citizens, selected at random at a community shopping center, were asked to identify the information sources they would use if they were in need of help.

The analysis of the counseling calls (objective three) was conducted by reviewing the case records of all

counseling calls received by a community I & R agency in the month of June, 1994. The agency defined counseling calls as those in which emotional and social support was provided to individuals experiencing distress yet the problems were not so severe as to be classified as a crisis intervention call. Of the 4,200 calls received by the agency in the month of June, 1994, 520 were classified as counseling calls. The case records of these 520 calls were analyzed for gender and age distribution, nature of calls, length of calls, and referral rates of counselors.
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Results and Implications

Sources of Information and Barriers to Obtaining Information
The first two objectives of the project were to identify sources of information used by individuals when they are in need of help and to identify barriers to obtaining information about community services. The major findings included the following:

- The majority of individuals in need of help first seek information from family members and friends. I & R agencies were cited as the second most frequent source of information followed by the yellow pages, physicians, police, newspapers, clergy, counselors/caseworkers, and service providers.
- Approximately 10% of the respondents in the citizen survey (N = 100) were unable to identify any source of help; 23% were unable to identify more than one source of information.
- Age differences were found in the identification of the first source of help. For all youth, 100% of the respondents indicated they would seek information from a friend as a first source of help and 92% stated they would also seek information from a family member. Teenagers were less likely than all other age groups to seek information from a member of the clergy or a physician.
- Barriers to trying to obtain help from the human service system were issues of pride and shame, lack of trust, and concern for privacy.
- System barriers cited were fragmentation of services, transportation problems for those needing help, application processing delays, categorical funding, bureaucratic obstacles, and lack of available, accessible services.
- The predominant cultural barriers among Hispanic/Latino citizens was the lack of services for individuals with limited-English speaking ability and the fear of deportation.
- African-American respondents cited barriers due to lack of service providers who were
- African-American or who were responsive to the African-American community. African-American respondents said they were more likely to turn to family members, neighbors, and clergy in times of trouble or crisis rather than to service agencies.
- Lack of bilingual ability and illiteracy were reported to be the major barriers to knowing about and using human services for the Southeast Asian community included in this project. Suggestions for providing information to these individuals included working with religious leaders (Buddhist monks, the refugee resettlement program sponsored by Catholic Charities, and various programs sponsored by the Protestant churches in the community), advertising on the local Southeast Asian radio station, and disseminating materials in appropriate languages at the Asian markets in the community.
- Barriers identified by service providers and information providers were the lack of common data bases containing current and accurate information for use by all information providers, the proliferation of I & R agencies, and the duplication of services by I & R agencies with similar purposes.

Counseling Call Analysis
The third objective of this project was to analyze the "counseling" calls received by an I & R agency to determine the nature of the problem, the extent of intervention provided by phone counselors, and the extent to which counseling calls were referred to other service providers. The major findings of this analysis included the following:

- A higher percentage of females (66%) than males (34%) sought support from the telephone counselors during the period of the analysis.
- The callers ranged in age from 17 to 67. In 88% of the records, the caller was the client; in 12%, the individual was calling on behalf of a child (6%) or another adult (6%).
- The highest percentage of calls (see Figure 1) were for emotional problems (30%), problems with a child or teenager (15%), substance abuse problems (11%), partner abuse (9%), financial problems (8%), child abuse (6%), suicidal thoughts (6%), relationship problems (4%), sexual assault victim (3%), health problem (2%), homelessness (2%), and work problems (2%).
- The shortest counseling call (1 minute) was made by a client requesting counseling services for sexual abuse. He did not want to talk to the I & R personnel, although he was quite distressed. He was referred to a local Abuse Center.
- The longest counseling call (45 minutes) was made by a client whose fiancee had been jailed for drug possession. She was shocked, angry, and distressed over the situation but wanted to preserve the relationship. She was referred to Nar-Anon.
- The telephone counselors offered referrals to approximately 50% of the callers. When referrals were not made, it was because no service was available or because a referral was not wanted or not appropriate.

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Implications

The outcomes of this project documented that I & R agencies serve as an important entry point that can facilitate early intervention services. However, the most frequently cited information sources were family and friends. Efforts should therefore be made to ensure the general citizenry is informed of community services and I & R agency services so that individuals and families will be able to obtain help when needed. It is imperative that I & R agencies have current and accurate information about service providers and community organizations and that they be trained to disseminate this information appropriately. There is also a need for communication linkages among the various information providers to avoid duplication of effort and to reduce caller frustration in seeking assistance.

The lack of bilingual and bicultural staff is a major obstacle to seeking help. There is a need to provide a wider variety of I & R services in culturally responsive ways to meet the needs of the different ethnic populations of local communities and to conduct outreach activities to help individuals in need of service locate and obtain assistance.

I & R agencies perform an important role in providing social and emotional support to individuals in distress as well as in times of crisis. It is therefore critical that these agencies be considered to be an important component in the system of care continuum and that they be included as one of several participants in the provision of family support. I & R agencies can be an important link in achieving the goal to provide information equity among at-risk children and their families.

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References

Balducci, P. (1994). A systematic study of Hillsborough County residents' appraisal of the human service needs in our community. Tampa, FL: United Way of Hillsborough County.

Dunlap, G. & Fox, L. (1995). Early intervention and serious problem behaviors: A comprehensive approach. In L. Koegel, R. L. Koegel, and G. Dunlap (Eds.), Community, school, family, and social inclusion through positive behavioral support. Baltimore, MD: Paul H. Brookes Publishers.

I-COPE (1992). 1992 coordinated human services needs assessment for Pinellas County. St. Petersburg, FL: United Way of Pinellas County.

Levinson, R. (1987). Information and referral services. In A. Minahan (Ed.), Encyclopedia of Social Work, Eighteenth Edition, Volume I (pp. 914 - 920). Silver Spring, MD: National Association of Social Workers.

Montenegro, M. C. & Batsche, C. (1995). Supplemental survey of Hispanic citizens of Hillsborough County who are limited in their English-speaking ability or who are Spanish monolingual. Tampa, FL: United Way of Hillsborough County.

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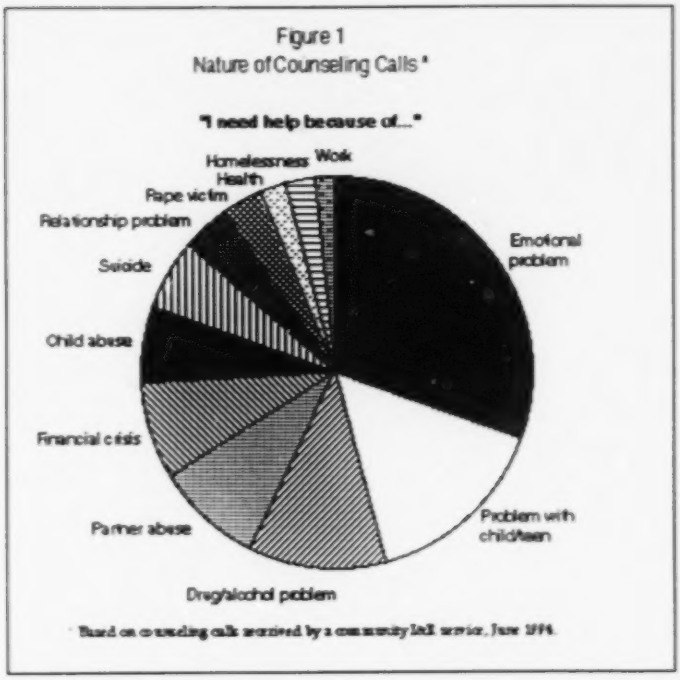

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Utilization of Children's Mental Health Services: Differentiating Families Who Use Community-Based Services from Those Who Do Not

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Introduction

One of the primary aims of the Vanderbilt School-Based Counseling Evaluation Project is to assess whether school-based mental health services increase the accessibility and use of services among children with serious emotional disturbance relative to traditional community-based services. This project presented a poster at the 7th Annual Research Conference for Children's Mental Health in which the service utilization rates of the project's school-based and community-based counseling groups were reported. At that time, the utilization rates for these two groups were highly discrepant in favor of the school-based counseling group. While the participation rate for school-based counseling was 99% (91 families), that for community-based counseling was only 17% (17 families).

In an effort to increase participation among families referred for community-based services, the project has implemented several significant changes in the recruitment and referral process. Instead of paying the customary fee for service to the community mental health center, the project now pays a portion of each therapists' salary to cover those hours devoted to scheduling and providing counseling services to participating project families. As a result, the project has been successful in recruiting a total of 46 (38%) families for community-based services. The finding that the rate of service acquisition for the community-based counseling group continues to be significantly lower than that for the school-based counseling group (i.e., 85%) strongly suggests that the school-based program provides mental health services to children who would otherwise go without needed services.
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Methods & Results

In order to understand better why some families seek community-based services and others do not, t-test comparisons were made on a number of theoretically determined variables.
No differences were found, however, on any of the following demographic variables: child's age, gender, or race; family income; education of primary caregiver; presence of a male in the household; prior use of mental health services; or the extent to which the family reported having reliable transportation.
Likewise, no statistically significant differences between groups were found on a measure of parental distress (Brief Symptom Inventory; Derogatis & Melisaratos, 1983), a measure of parent involvement in the child's daily life, or a measure of the frequency with which various strategies are used to resolve conflicts between the parent and identified child.

Since primary caregivers are instrumental in obtaining services once a referral is made, their perceptions of child functioning were expected to distinguish between those who follow through on the referral for services and those who do not. A comparison of scores on the parent version of the Child Behavior

Checklist (CBCL; Achenbach, 1991) showed a trend indicating that seeking treatment was associated with higher (i.e., more disturbed) CBCL scores ($t = -1.83$, $p = .07$). This was also the case for externalizing symptoms ($t = -1.67$, $p = .09$), but this finding did not hold true for internalizing symptoms ($t = -0.50$, $p = .61$). Likewise, parent perceptions of their child's interpersonal strengths also distinguished between the two groups. Parents who sought services for their child reported significantly fewer interpersonal strengths for their child than those parents who did not obtain these services ($t = 2.20$, $p < .05$).

In addition, scores on the Family Assessment Device (FAD; Epstein, Baldwin & Bishop, 1983) were significantly different for service utilizers and nonutilizers. Families who sought treatment had significantly lower mean scores on the General Functioning Index of the FAD than did those who had not yet obtained services ($t = 3.24$, $p < .001$). This was also the case for the Problem-Solving subscale ($t = 3.59$, $p < .001$), the Affective Responsiveness subscale ($t = 4.41$, $p < .001$), and the Behavioral Control subscale ($t = 3.02$, $p < .01$) of the FAD. Other subscales of the FAD that were not significantly different between the two groups included Affective Involvement, Communication, and Roles/Responsibilities.

In an attempt to learn why some families decided against accessing the services for which they had been referred, a Nonattendance Questionnaire was administered during the project's most recent home interview (i.e., Summer, 1994). In light of the finding that families reporting higher family functioning were less likely to access services, it is interesting to note that among the most frequently endorsed items were "I can handle my child's problems on my own," and "Children's problems tend to work out by themselves." Likewise, the high frequency with which the item "My child didn't really have a problem" is consistent with the finding that families who
did not access services reported fewer problem behaviors for their children on the CBCL.
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References

Achenbach, T.M. (1991). Manual for the Child Behavior Checklist/4-18 and 1991 Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. Psychological Medicine, 13, 595-605.

Epstein, N.B., Baldwin, L. M. & Bishop, D. S. (1983). The McMaster Family Assessment Device. Journal of Marital and Family Therapy,
9, 171-180.
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Children's Mental Health Needs and Services in an Urban Area: Mapping and Analysis

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Introduction

Previous studies in Psychiatry have attempted to understand the influences of city life on psychopathology and development in children. For the most part, these studies have dichotomized environments into urban and rural areas with the underlying hypothesis that all urban areas are experienced by inhabitants as stressful and deleterious to their mental health. However, environmental stress is not distributed uniformly within a city&shyp;there are safer areas and less affluent areas. Therefore, wholesale comparisons of urban versus rural populations may not make sense. Mapping as a methodology offers an alternative wherein the micro-environments that neighborhoods offer can be examined with more precision. These environments can then be compared with the populations that live within these neighborhoods.

With these methodological considerations in mind, one can begin to examine how neighborhood environments are related to children's mental health and the use of mental health services. The associated hypothesis that can be examined is one that was most explicitly stated in Unclaimed Children (Knitzer, 1984): Distribution of mental health services is uneven and may be most scarce in areas of highest need. This preliminary study attempted to use mapping and statistical techniques to begin to address these issues.

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Methodology

The setting for this preliminary study was a small city of 124,000 people located in the Northeastern United States. The median family income in 1990 was $15,000 and 31% of families were living below the poverty level. Three main concepts are defined for study: (1) mental health service use, (2) mental health service need, and (3) the ratio of mental health service use to mental health service need. An estimate of mental health service use was obtained by enumerating cases seen at a child guidance clinic. These index cases were geo-coded and plotted within census tract block groups of the city. Child protective referrals were enumerated and used as an indicator of disturbances in mental health with respect to children and families in each census tract. Federal census tract data were used to characterize attributes of each census tract block group.

In order to represent the relationship of mental health service need to service use, an index was constructed&shyp;number of cases enrolled in the mental health clinic per block group was divided by the number of child protective referrals per block group; this was done for each block group. This index was referred to as the mental health service use to need ratio. This index will be larger if the ratio of service use to service need is high. However, if there is greater need or less mental health service use, then this index will be lower.

Data for this study were gathered from one of the publicly funded child guidance clinics whose staff sees about 1,200 children per year&shyp; about one-third of the child mental health cases served in the urban center. The city was small enough in area that patients could move freely between the child guidance agencies. Data were also obtained from the state child protective service. Information from these two agencies was downloaded from the agencies' computer system to a centralized PC. In addition, US 1990 Census data and a citywide survey of vacant housing were used. Census and neighborhood survey data provide proxies to characterize the neighborhood environments.

Computer assisted mapping was done using MapInfo, locating cases within US census tract block groups. Using these data sources and techniques, data for each block group were compiled and statistically analyzed using SYSTAT.

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Results

This study revealed that an average of two percent of the entire population who were less than 18 years of age received mental health services over a five year period. This figure compares favorably with similar surveys done elsewhere in the U.S. Maps produced from these data, however, show considerable variation within the city in terms of distribution of these services. Considering each of the 129 block groups located within the city limits, anywhere from zero to nine percent of the population received services over a five year period. Service intense block groups are scattered throughout the city and not clustered around the child guidance clinics.

In a four month period, there were from zero to fifty child protective referrals per one thousand population in each of the 129 city block groups, with an average of seven referrals per one thousand population. Again, the density of referrals per block group shows scatter and variability.

The percentage of vacant buildings offers one view of a city neighborhood. Other characteristics of a city neighborhood include unemployment rate, ethnic mix of the population, proportion of households that move, family income, and percentage of homes below the poverty level. These characteristics may be considered different aspects of urban stress. It was hypothesized that these measures of urban stress impact the mental health of the members of the neighborhood and hence are related to mental health service use and need.

In order to examine the potential relationships between these environmental factors and mental health service use and need, statistical regression analysis was used. These analyses show that child protective referrals as a proxy for mental health service need are directly proportional to the unemployment rate and the percent of the population that is not Caucasian. Mental health need as represented by child protective referrals is not statistically related to poverty levels, proportion of the population that is English speaking, proportion of the population graduating high school, proportion of the population moving into the area in the last five years, population density, or proportion of buildings that are vacant.

The amount of mental health service provided is directly proportional to the unemployment rate. In those areas with highest urban stress as measured by high numbers of vacant buildings, the amount of mental health services is also related to the number of people living in the same area for longer than five years. The density of mental health cases, however, is not related to percent of the population which is of minority status, population density (number of people/number of buildings), percent of high school graduates, percent of English speaking families, or proportion of families living in poverty.

The use to need ratio, as was mentioned above, represents the extent to which mental health problems are being addressed by services. This index provides a test of whether or not the most severely stressed areas of the city are receiving adequate mental health services, or as suggested by Knitzer (1984), whether the most disadvantaged children are receiving fewer services than less disadvantaged children. In fact, statistical analyses reveal that a high child protective referral rate is associated with a low index use to need ratio, providing confirming evidence for the hypothesis that those most in need are not receiving mental health services. A high proportion of members of ethnic/racial minorities within the population is also associated with a low use to need index. This result indicates that non-minority populations avail themselves of mental health services more than do members of minority populations.

If we consider those 15% of census tracts of the city that have higher stress as measured by percentage of vacant buildings, we discover that a high use to need index is associated with the highest percentage of vacant buildings and the highest population densities, in addition to the above findings. These findings indicate that people living in areas of highest population density and highest urban stress do avail themselves of mental health services when they need them.
What is equally important to note is that the use to need index is not related to employment, migration, poverty levels, percentage of the population that speaks English, or percentage of the population who has graduated high school. These negative findings demonstrate that when child protective referrals are high, children from that neighborhood are using mental health services, whether or not they are poor, speak English, have graduated high school, have recently moved or are employed.

These findings are preliminary, especially since they use data from only one of three public mental health clinics. Therefore, these findings need to be confirmed by additional data collection and analyses.
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References

Knitzer, J. (1982) Unclaimed Children: The failure of Public responsibility to children and adolescents in need of mental health services. Washington, DC: Children's Defense Fund.
MapInfo Software from MapInfo Corporation, 1 Global View, Troy, NY 12180-8399.
SYSTAT Software for SYSTAT, Inc., 1800 Sherman Ave, Evanston, IL 60201-3793.

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Addressing the Barriers to Mental Health Services for Inner-City Children and their Caregivers

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Introduction/Purpose

Developing the means to address barriers to help seeking is critical given that lower income, minority children are at greater risk for the development of psychopathology. This paper outlines a series of three research studies designed to identify factors related to children's mental health service usage and barriers to help seeking for urban minority children and their caregivers. In addition, this paper describes the systematic development and evaluation of a telephone intervention strategy aimed to increase overall attendance at initial intake appointments at an urban children's mental health agency. The first study explores differences in demographic variables, for two groups of children, those that came to an initial intake interview and those that requested child mental health services, but failed to come to any scheduled appointments (n=450). The second study evaluates a telephone engagement intervention meant to increase initial attendance (n=54). Finally, the third study more rigorously evaluates the impact of an intensive telephone intervention on initial attendance rates by randomly assigning families to the more focused telephone intervention or a "business as usual" telephone screening (n=108).
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Method/Procedures

The series of studies were meant to reach the following objectives: 1) to document demographic characteristics of those children and families who requested mental health services at an urban agency; 2) to explore differences between those children and families that requested services but did not come for an intake appointment and those that came for an intake appointment;
3) to identify factors that would predict attendance at the initial appointment and; 4) to develop and evaluate a telephone intervention strategy based upon the empirical findings of previous mental health services literature.

Research Site
All three studies were conducted at the Institute for Juvenile Research (IJR), the Child Psychiatry Division of the University of Illinois at Chicago. IJR is an inner-city, child mental health agency, with 67.3% of the children living with their mothers in single parent households. Approximately, 85% of the 450 families who requested services last year were supported by Public Assistance. Almost two thirds of children seen at the agency were African American,
12% were Latino and the remaining portion were Caucasian.

Study #1
Of the 450 children who were referred to
the Institute for Juvenile Research and an intake appointment was scheduled, the following demographic information was obtained: age of identified child, gender of child, primary and secondary caregivers, presenting problem and, court involvement. These children were then tracked through the intake system at the agency.

Study #2
The next study aimed to systematically develop and evaluate a telephone intervention strategy with the primary goal of increasing overall attendance at initial intake appointments. Two master's level interns, under the direction of a clinical faculty member implemented the 30-minute telephone engagement intervention. This intervention focused on: helping the primary caregiver invest in the help-seeking process by clearly identifying their child's presenting difficulties; framing caregiver's actions as having the potential to impact the current situation; and having the caregiver take some concrete steps to address the situation, even prior to the initial appointment. In addition, the inter-vention was intended to systematically explore barriers to help seeking, both within the family and the environment. Finally, an active problem solving approach was used to develop the means to address obstacles to contact with the agency.

A sample of twenty-seven telephone intervention cases were compared to the first twenty-seven cases scheduled for intake appointments in the same month of the previous year.

Study #3
Next, in order to address some of the limitations of the previous study related to sample size and design, the investigator evaluated the telephone intervention strategy by randomly assigning 108 new requests for child mental health services to one of two conditions. In the first condition, 55 telephone intakes were assigned for a thirty minute, intensive engagement intervention with two Master's level social workers. The second condition consisted of a routine telephone screening lasting approximately 30 minutes conducted by a third master's level social worker (n=53). This screening related to the presenting problem of the child and appropriate fit for the agency.
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Results

Study #1
Only 277 (61.6%) of the 450 children accepted for intake appointments were ever brought in by their caregiver. In relation to gender of the child, 64.5% (n=290) of all children accepted for service at the agency were male, however, only 176 (60.7%) actually came for an intake appointment. In comparison, girls were more likely to be brought to at least one appointment. Of the 160 girls accepted for intake appointments, 101 (63.1%) actually came to at least one appointment. When primary caregiver was considered, 302 children (67.1%) were being cared for by their mothers at the time of the initial call to the agency. Only 170 of these children (56.3%) were ever seen for a first interview. Children who were parented by foster care givers were more likely to come in for scheduled appointments, 119 intakes were scheduled by foster parents and 91 (76.5%) of those appointments were kept.

In relation to presenting problem, children were most likely to be referred for aggressive behavior (n=106 intakes scheduled) or ADHD symptoms (n=79). However, only 62 (58.4%) of children with aggressive behavior and 35 (44.3%) of children presenting with ADHD features ever came for an initial appointment. Children identified as having been severely abused or experiencing severe trauma were more likely to be brought to an appointment&shyp;22 appointments scheduled vs. 16 (72.7%) appointments kept. Children who did not have court involvement more often contacted the agency (n=309), but only 173 (56.0%) of these children were ever brought to the agency. Families who were involved with the Juvenile Court were more likely to follow through with a scheduled intake appointment &shyp;103 (75.2%) of the 137 intake appointments were kept.

Study #2
Results reveal that the engagement strategy increased initial appointment attendance by 29% in comparison to the more traditional telephone intake procedures. Of the intervention families, only 6 did not come to an initial appointment, in comparison to 14 no shows for the same month the preceding year. Chi square analyses revealed a significant increase in intake attendance for the intervention children and families ($c2 = 5.08$, $p < .05$).

Study #3
Of the 55 families that received the telephone intervention, 72.7% (n = 40) came to the first appointment or called at least a day prior to the interview to reschedule. Of those that underwent the more traditional screening, only 45.3% came to the appointment or called independently. Chi square analyses revealed significant results ($c2 = 8.42$, $p < .01$). Logistic regression was then used to explore contribution of age of child, court involvement, primary caregiver and gender of the child, however, these demographic variables did not add significant explanation.
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Implications

Thus far, the telephone engagement intervention discussed above has demonstrated efficacy for increasing initial attendance by inner-city families. However, its impact in relation to ongoing engagement is still being evaluated. Further research is needed to accurately estimate the cost effectiveness of this approach and the impact that such a shift in agency procedures has on efficiency, staff morale, etc.

The foundation for any future children's mental health services research is the ability to engage children and their caregivers in services.

If clients do not access services or remain in service for a sufficient period of time, the efficacy of any mental health treatment cannot be tested. Larger research initiatives are clearly needed if there is to be an increase in quality and access to care by minority children and families. In light of the growing concern about the inappropriate use of costly, restrictive treatment for children, this paper has begun to examine issues related to increased use of outpatient children's mental health services.
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Referral Bias?: A Clinical Comparison of African-American and Caucasian Children Referred to a Child Psychiatric Outpatient Clinic

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Introduction & Purpose

The question of referral bias is particularly relevant in children's mental health, as children rarely refer themselves. Referral source and presenting problem are particularly germane to this question of bias as they reflect who perceives what kind of problem. A critical question is whether intrinsic background characteristics of the child, such as ethnicity, affect the process of referral and evaluation for behavioral and emotional problems. In the context of the burgeoning literature on the role of cultural congruency in mental health service delivery, it becomes important to examine the issue of bias in referring minority children for services.

Building on previous studies, we were interested in examining our clinic population to explore the question of referral bias. Controlling for socioeconomic status, gender, and age, we wished to examine whether in our clinic African-American children when compared with Caucasians were:

1. more likely to be referred by coercive referral sources (e.g., courts)
2. have more severe (externalizing) presenting problems
3. have similar levels of psychiatric impairment.

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Procedures

Subjects

The 206 subjects were taken from the total 683 clients who contacted the Child Study Center (CSC) from July 1, 1992 to June 30, 1993. Forty-eight percent of the children who come to the clinic are from New Haven&shyp;the remaining 52% are from the outlying suburbs(34%) and the rest of the state (18%). Over half of the children are Caucasian (55%), 31% are African-American, 14% Hispanic. Over 600 children are enrolled as new cases each year.

Our sample consisted of subjects who were (a) either African-American or Caucasian, (b) were referred for primarily an externalizing or internalizing problem and (c) received at time of evaluation a primary DSM-III-R Axis I diagnosis reflecting an internalizing or externalizing disorder. Overall, these 206 subjects represent 30% of clients who contacted the clinic during that year. The sample was 57% male (n = 117) and 43% female (n=89); 31% (n=64) African-Americans and 69% (n= 142) Caucasian.

Site
The study site is a university based inner-city children's mental health clinic that accepts patients on a sliding fee scale according to the family's financial status. Contact begins with a phone call from the parent or other referring source. The intake secretary records age, gender, place of residence, school, family composition, presenting complaint(s), previous evaluations and treatments. Parents are mailed an application packet consisting of an introductory report form covering parents perception of the child, the Family Environment Scale (FES; 25), the Child Behavior Checklist (CBCL; 26), releases of information for the school, pediatrician, and previous treatment providers, a questionnaire regarding financial information, and a stamped, addressed return envelope. Once the packet is returned, the case is opened and assigned to a multidisciplinary team for evaluation.

Analytic Plan
We were primarily interested in examining characteristics of African-American and Caucasian patients. Thus, subjects were compared using
chi-square analyses on a number of relevant categorical variables, including gender, age, single vs. two-parent home, urban vs. suburban residence, pay status (insurance vs. Title XIX), Hollingshead Index, referral source (coercive vs. non-coercive) and presenting problem (internalizing vs. externalizing).

We wished to investigate whether African-Americans and Caucasians differed in likelihood of being referred for an externalizing or internalizing problem, of being referred coercively, and in DSM-III-R diagnosis, which would be assessed at the end of the evaluation period. To test these hypotheses, we again utilized chi-square tests. To examine whether groups differences existed on a parent report measure of symptomology, the CBCL, and a therapist measure, the C-GAS, ANOVA's were conducted with ethnicity as the independent variable. To understand the relationship of ethnicity to presenting problem we utilized log linear analyses to control for gender, SES and coercive referral.
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Results and Implications

When we compared African-American and Caucasian patients we found no differences in gender or age. However, a significantly higher percentage of African-Americans came from the immediate New Haven urban area as compared to Caucasians (80% vs. 17%). In addition, significantly more African-Americans came from single parent families (82% vs. 55%) and were on Medicaid (75% vs. 38%). Compared to Caucasians, a greater number of African-American patients appeared to be disproportionally distributed in the lower SES brackets of the Hollingshead (Classes IV, V; 71% vs. 46%).

At the time of intake, African-Americans were almost 3 times more likely than Caucasians to be referred by coercive sources (61% vs. 22%). Also, African-Americans were significantly more likely than Caucasians to be referred for externalizing disorder at intake (88% vs. 67%). Of the children who presented with externalizing behavior, 55% of the African-American children were referred by coercive sources, compared to 15% of the Caucasians.

When African-American and Caucasian children were compared on the CBCL, more African-American parents reported externalizing symptoms ($p < .05$). However, this difference was no longer significant when we controlled for SES. African-American and Caucasian children were not rated differently on the internalizing scale.

On a therapist rated measure of global functioning, the C-GAS ratings for African-Americans and Caucasians did not differ significantly. There was no significant difference in the proportion of externalizing or internalizing diagnoses between African-Americans and Caucasians.

Eighty-eight percent of African-Americans were referred for an externalizing problem, and 12% for an internalizing problem. At the completion of evaluation, however, 50%

received an externalizing diagnosis and 50% an internalizing diagnosis. Similarly, 67% of the Caucasians were referred for an externalizing problem, 33% for an internalizing problem; at evaluation 36% of this group received externalizing diagnoses, and 64% internalizing diagnoses . Log linear analysis was utilized to examine the relationship between ethnicity and reason for referral while statistically controlling for SES (I-III vs. IV-IV), referral source (coercive vs. non-coercive) and gender, as well as, the interaction of ethnicity and referral reason. Results indicate that once the variance attributable to these variables was partialled out, that African-American children were still more likely than Caucasians to be referred coercively ($Z = 5.08$, $12 < .0001$), and more likely to be referred for an externalizing rather than an internalizing disorder ($Z = 3.93$, $p < .0001$).
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Discussion

In our study, the African-American children and adolescents were primarily from the city, from single parent families, socioeconomically disadvantaged and likely to be coercively referred for an externalizing problem. In contrast, Caucasian children and adolescents were likely to be from the suburbs, insured, from two parent families and to be non-coercively referred for an evaluation. However, their diagnoses indicated similar levels of psychiatric impairment. In our analysis this held when we controlled for gender and SES for the African-American group. The findings in our clinic corroborate those of other studies. Compared to Caucasians, African-American children, despite a similar clinical profile were at greater risk for coercive referral and for externalizing presenting problems.

One speculates, with other authors, about the perception of African-Americans by referring agencies. Fabrega and colleagues (1993) observe that "social systems appear" less tolerant of AfricanAmericans and hence their group may be "selected for," in that the social system compels them to obtain (not select) care (p. 412). This interpretation is supported by the finding discussed above. These authors question the assumption that minorities avoid seeking psychiatric help, resulting in delay in obtaining needed service. They suggest the opposite&shyp;based on their findings&shyp;that AfricanAmericans may be "shunted" to psychiatric service earlier than Caucasians as a result of more surveillance and discomfort on the part of social agencies. Takeuchi and colleagues (1993) suggest a labeling perception on the part of social service agencies. However, they identify poverty, rather than race, as the identifying characteristic which elicits labeling. Since most of the African-American children seen are poor, there is more likelihood that they may be referred by the myriad social service agencies with which they have contact. Although our findings point to similar conclusions, our results were not altered when we controlled for SES. Hence, this tentatively suggests a more general referral bias that goes beyond socioeconomic disadvantage.

Of the possible explanations for our findings, referral bias seemed the most plausible given the results of this study and previous research; however, the role of ethnicity and race in psychopathology is complex and poorly understood, and this conclusion is tentative. Further research controlling for factors such as socioeconomic status is needed to examine relationships between ethnicity and psychopathology and the presence of bias in mental health services.
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References

Fabrega, H., Ulrich, R. & Mezzich, J. E. (1993). Do Caucasian and Black adolescents differ at psychiatric intake? Journal of the American Academy of Child and Adolescent Psychiatry, 32, 2.

Takeuchi, D. T., Bui, K. T. & Kim, L. (1993). The referral of minority adolescents to community mental health centers. Journal of Health and Social Behavior, 34, 153-164.
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